STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

approved NB 9/9/13

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a recertification survey conducted 8/12/13 through 8/15/13. Representing the Department: HFEN 29825 HFEN 31463 HFEN 31701 HFEN 32096 Facility census was 114 (including 1 bed hold) and sample size was 23.	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure professional standards of quality were met for 2 out of 23 sampled residents (11 and 20) and 1 out of 21 random residents (R) when: 1. Physician orders were not followed for fall mats (mat placed beside a bed to help prevent injuries from falls) for Residents 11 and 20, placing the residents at risk for injuries from falls. 2. A medication was administered without a physician's order for random resident R. Findings:	F 281	F281 a. The fall mats for residents 11 and 20 were placed at the bedside per the physician order. A physician order was obtained for resident R for oxygen. b. Physician orders for fall mats as an intervention for low beds were all audited to ensure that orders were implemented. Any resident using oxygen was audited to ensure that an oxygen order was prescribed by the attending physician.	09/05/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9-5-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 1.a. Resident 11 was admitted to the facility on 7/2/13 with diagnoses including hepatic encephalopathy (changes in the brain that occur with advanced liver disease). On the Initial Tour on 8/12/13 at 8:20 a.m., Resident 11 was observed to be lying in bed with side rails up. An observation of the floor next to the resident's bed revealed no fall mat. A second observation on 8/13/13 at 9:30 a.m. revealed the resident lying in bed with full side rails up and her right lower leg over the top of the side rail with her right hand reaching toward the side rail. There was no fall mat next to the bed. In an interview with the resident's [responsible party] on 8/14/13 at 1 p.m., she stated that the facility told them the fall mat could not be used because there was no doctor's order for it. In an interview with Evening Manager (EM) on 8/14/13 at 1:25 p.m., he confirmed the fall mat was not in place and was unable to provide a reason it was not being used. A review of Resident 11's clinical record revealed a physician order on 7/22/13 for "Low bed with mat on floor to protect if resident rolls out of bed". The clinical record also revealed a "Fall Risk Care Plan" dated 7/22/13 which included "low bed with mat to protect if she rolls from bed." 1.b. Resident 20 was admitted to the facility on 8/7/13 with diagnoses including a history of falling, seizure disorder, vision disturbances, stroke and visual hallucinations. Review of Resident 20's Nursing Admission Assessment, dated 8/7/13, documented Resident 20 had dementia, was disoriented/confused,	F 281	c. The director of nursing shall in service licensed staff on physician orders. A system is in place for all physician ordered safety interventions pertaining to any resident needing additional safety precautions. This shall be checked by the medication nurses each shift. A system is in place to identify all residents receiving oxygen therapy. This list shall be updated and used for auditing and quality assurance purposes.	

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F 281	Continued From page 2 visually impaired, had impaired balance, had an unsteady gait and required extensive assistance with all activities of daily living except eating. During an observation on 8/15/13 at 9:50 a.m., it was noted there was no fall mat next to Resident 20's bed. Review of Resident 20's Physician Telephone Orders, dated 8/7/13, documented "- mat on floor to protect if she rolls out of bed." A review of Resident 20's document titled "Fall Risk Care Plan", dated 8/7/13, did not document there was a fall mat order. During an interview on 8/15/13 at 9:55 a.m. Case Manager 1 verified the absence of a fall mat and also noted it was not mentioned on the care plan for falls. During a concurrent record review, observation and interview with the Director of Nurses (DON) on 8/15/13 at 10:06 a.m., she verified there was a doctor's order for a fall mat for Resident 20 but it was not at her bedside. Review of the facility policy and procedure titled Physician's Orders: Carrying Out, dated September 2007, established " Every licensed staff member will note and carry out physician orders as received..." 2. Random Resident R was admitted to the facility on 7/31/13 with diagnoses including lung disease. On 8/13/13 at 4 p.m., Random Resident R was observed to receive oxygen via nasal cannula (a	F 281	d. The nurse supervisor, medication nurses shall be responsible for ensuring that all physician orders are carried out in addition to ensuring that all orders are in place for oxygen. The facility has a system whereby all new orders are reviewed the following day. The director of nursing shall monitor. The compliance to these systems shall be forwarded to quality assurance and assessment committee for review and action. e. This corrective action shall be completed by September 15, 2013.	9/15/13

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F 281	Continued From page 3 plastic tube to deliver supplemental oxygen). A review of the clinical record revealed Random Resident R did not have the physician's order for oxygen. In an interview on 8/13/13 at 4:10 p.m., Licensed Nurse 4 verified there was no physician's order and stated, "She uses it [oxygen] occasionally when she is short of breath... She's been getting O2 [oxygen] prn [as needed]." A review of the facility policy and procedure titled, "Oxygen Administration," revised 03/04, under Preparation, wrote, "1. Verify that there is a physician's order..." [Professional Standards of Nursing are referenced in the California Nursing Practice Act.]	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an evnironment as free from hazards as possible when the following were observed: An unlatched, open gate with a sign that the gate remain closed, from the patio/garden area to the	F 323	F 323 a. The hazards were addressed. The gates were latched. The holes were filled in with dirt. The fence boards with protruding nails were hammered down to prevent injury. The uneven concrete in the patio will be scheduled as a capital expense repair. The thermostat in room 43 was replaced. b. Safety rounds with the maintenance team occurred on 8/14/2013 and the entire facility was reviewed. The facility is addressing other hazards on the premises where residents are vulnerable to resident injury.	9/15/13

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F 323	Continued From page 4 southwest side of the building. This area contained: - two large holes in the ground, approximately 2 ft. in diameter by 18 inches deep, - boards with nails protruding out of the side, and, Uneven concrete areas in the patio area. An uncovered thermostat in room 43 exposed electrical wires and potential shock hazard to the residents in that room. These failures created the possibility of injury to residents. Findings: During the initial tour of the facility on 8/12/13 at 8 a.m., general observation of the facility on 8/13/13 between 6:30 and 8:30 a.m. with Maintenance Engineer 2 (ME 2), and ongoing observations during the survey, the following hazards were noted: - An unlatched gate, with a sign stating the gate was to be closed at all times, led to the west side of the building from the patio. The side of the building had the following hazards: - two large (about 2 feet in diameter and about 18 inches deep) holes were found in the dirt outside of the exit doors on the southwest side of the facility, and - boards with protruding nails were found along the side fence by the holes in the ground. Inside the patio area uneven concrete sections created trip hazards. The patio area was being used for smoking, visiting, and activities as the facility garden was in this area. Ambulatory residents as well as those in wheelchairs and using walkers were observed using the area during the survey. One area of concrete was	F 323	c. Facility safety inspections will be conducted weekly to address any potential hazards. The administrator shall in-service the maintenance department on resident safety. The facility has a system to address safety each quarter. Issues will be identified and addressed during the safety committee. The administrator shall make rounds with the maintenance director to address safety concerns. The maintenance director shall be a safety committee member. d. Resident safety is monitored by maintenance department. Resident safety is an integral part of our quality assurance and assessment committee. Results of resident safety shall be reviewed at the quality assurance and assessment	9/15/13

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F 323	Continued From page 5 about 2 - 3 inches higher than the next concrete area that had been "fixed" with a patch of concrete between the two. The slope of the "fixed" area was steep enough to create a trip/fall or possible wheelchair or walker accident. - An uncovered thermostat in room 43 exposed electrical wires. On 8/13/13 during a tour and interview from 6:30 - 8:30 a.m. ME 2 acknowledged the holes in the ground and boards with nails. The thermostat without a cover was also acknowledged during the tour and interview. During a tour on 8/14/13 at 3:30 p.m. with EM the uneven concrete areas were examined. Residents in wheelchairs and ambulatory residents were observed using the patio at the time. During a concurrent interview with the EM he acknowledged the potential hazard and agreed that a safer slope between the two levels of concrete would lessen the potential for trips and wheelchair accidents. A review of the facility policy titled "Safety and Supervision of Residents" states, ". . . the facility strives to make the environment as free from accident hazards as possible." Three of the identified resident risks and environmental hazards stated in the policy include falls, smoking, and unsafe wandering.	F 323	committee for review and action. e. This corrective action shall be completed by September 15, 2013. F332 a. The nurse (LN2) will be inserviced on the correct procedure for medication administration. LN2 indicates that the resident received all medications per the order during the medication pass. b. The director of nursing shall do a medication pass with LN2 to assess nurse competency.	9/15/13
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure residents were free of medication error rates of 5 percent or greater for 2 of 7 randomly observed residents (Random Resident T and Random Resident S) during the medication pass when: 1. Random Resident T received an incorrect dose of medication; and 2. Random Resident S did not receive medication as ordered. A total of 2 errors out of 26 opportunities resulted in 7.7 percent medication error rates. Findings: 1. On 8/13/13 at 6:25 a.m., Licensed Nurse (LN2) was observed to administer medications for Random Resident T. Reconciliation of the observation and the physician's orders for Random Resident T revealed Lexapro (anti-depressant) 10 mg (milligram) was not administered. In an interview on 8/14/13 at 7:40 a.m., LN2 acknowledged Random Resident T had Lexapro order and stated, "I don't remember [not administering Lexapro]." 2. On 8/13/13 at 7:13 a.m., LN3 was observed to administer medications to Random Resident S. Reconciliation of the observation and the physician's order revealed Random Resident S received 1 tablet of Tylenol 325 mg when the physician's order was 2 tablets of Tylenol 325 mg (650 mg). In an interview on 8/14/13 at 7:35 a.m., LN3 verified Tylenol order was 2 tablets of 325mg and stated, "I don't know how I gave only	F 332	c. The director of nursing shall inservice medication nurses on medication pass. Medication observation for new nurses will be a part of the annual and new licensed nurse competency program. d. Effectiveness of the medication administration shall be incorporated into the quality assurance and assessment committee and reviewed for action semi annually. e. This corrective action shall be done by September 15, 2013.	9/15/13

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F 332	Continued From page 7 1 [tablet]."	F 332	F371	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of clinical records and facility policies and procedures, the facility failed to store and serve food under sanitary conditions for 1Random Residents (L) when a personal refrigerators contained undated or outdated food. Findings: 1. During an initial tour of the facility on 8/12/13 at 8:10 a.m., a personal fridge was noted in the room of Random Resident L. Observed inside the fridge were the following undated or expired items: > A container of red gelatinous substance > A container of green sauce > A container of white rice > A container of yellow and red colored food substance > A container of white yogurt > Flat bread wrapped in plastic	F 371	a. The contents of the personal fridges were either discarded or labeled and dated. b. The other personal fridges used within the facility were checked to ensure that families were appropriately dating and labeling the contents of all items. c. The social services department shall conduct an informational session with the family or resident on the rules and regulations pertaining to personal fridges. Any family or resident that has a fridge will be responsible to abide by the policy on covering, dating, labeling of all contents in addition to cleaning the fridge at least monthly. The environmental staff will check daily to	9/15/13

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F 371	Continued From page 8 > A bottle labeled Peppermint water > A 4 oz. carton of milk dated Aug. 3 During a concurrent observation and interview with the Director of Nurses (DON) on 8/14/13 at 8:43 a.m., the personal fridge was rechecked in the room of Random Resident L. Inside the fridge were the following undated items: > A container of hummus > A container of red gelatinous substance > A container of white rice > Flat bread wrapped in plastic > A Styrofoam container of old Chinese food > A bottle labeled Peppermint water The DON said the facility was not responsible for cleaning the fridge. "It's the family's job." She also said they told Resident L's daughter the family was supposed to label the food with dates and throw it out after 3 days. She also said the caregiver came almost daily and should have been checking that all food was dated. Review of Resident L's clinical record on 8/14/13 showed a document titled "Cold Storage of Food". It was the instructions for refrigerating food, wrapping and labeling the items, cleaning the refrigerator including the gaskets, checking the refrigerator temperature, inspecting and servicing the motors, compressor belts and condenser, lubricating hinges and latches. The DON said they had given it to the family and it should have been signed. The DON verified there was no date or signature of family, caregiver or facility staff on the document.	F 371	ensure that contents in the fridge are within regulation. If items are not within policy, then social services shall be informed for proper follow up. d. The personal fridges shall be monitored by the environmental staff. Compliance to the policy shall be monitored and addressed in quality assurance and assessment committee for review and action. e. This corrective action shall be done by September 15, 2013.	9/15/13
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 9 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to report an identified irregularity to the attending physician for 1 of 23 sampled residents (7) reviewed. This failure increased Resident 7's risk for adverse consequences related to use of antipsychotic medication. Resident 7's record review revealed the following: Resident 7 was admitted to the facility on 9/29/11 with diagnoses including dementia and had been on hospice since admission. Resident 7 had a physician's order dated 3/2/12, "Haloperidol [antipsychotic medication] 2MG/ML [milligrams/milliliter, units of dosage], give 1mg (0.5ml) PO Q [by mouth, every 4 hours] 4 hours as needed for dementing [sic] with associated behavior symptoms m/b [manifested by] significant decline in function or refusing care." Resident's Medication Administration Records (MAR) for the months of June, July and August of 2013 showed a sudden increased use of Haldol as follows: In June: Haldol [Haloperidol] was administered 1	F 428	F-428 1. Resident #7 the MD was notified of the increase in the usage of Haldol, but did not make any changes in the medication order secondary due to the resident is Hospice and followed Hospice Protocal. 2. Pharmacist Consultant will review monthly all resident currently on psychotropic medications for any need for GDR'S or any increase usage of any psychotropics. And will refer any concerns to the DON or MD. 3. Pharmacist Consultant and DON will review monthly all resident on psychotropic medications any need for GDR's or and increase usage of the psychotropic medication and refer the concerns to the MD, If the resident is Hospice, the Hospice Nurse and Md will be notified for any changes.	9/15/13

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F 428	Continued From page 10 time In July: Haldol was administered 22 times In August: As of 8/13/13 Haldol was administered 15 times. Resident 7's monthly "Drug Regimen Review Pharmacist Signature Log" reviewed and found there was no pharmacist's recommendations for Resident 7's increased use of Haldol for the months of July and August, 2013. In a telephone interview on 8/15/15 at 12:55 p.m., the Pharmacy Consultant (PC) for the facility stated she was aware of the increase use of Haldol PRN in July and in August and stated she didn't bring the identified irregularity to the attending physician due to "[The] resident is on hospice...I made self a note to follow up in September." A review of the facility policy titled "Administering Medications," revised 12/12 read, "25. If a resident uses PRN [as needed] medication frequently, the Attending physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed shall reevaluate the situation...determine if there is a clinical reasons for... and consider where a standing dose of medication is clinically indicated."	F 428	4. DON and Pharmacist Consultant will review monthly any residents on psychotropic medication for any need for GDR's or any increase usage of the psychotropic medications and will refer it to the MD. If the resident is Hospice then the Hospice Nurse will be notified. 5. Date completed 9-10-2013	9/15/13
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	F431 a. A thermometer was placed in both medication rooms to monitor the proper storage temperature of drugs and biologicals. A log was implemented to record all temperatures. The nurse supervisor shall document temperature of medication room daily.	

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F 431	Continued From page 11 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and documentation review, the facility failed to ensure medications were stored under proper temperature controls for a census of 114 when the drug room temperature was not monitored for 1 of 2 drug storage rooms inspected. This failure placed residents at risk to receive potentially compromised medications.	F 431	b. A thermometer was placed in the other medication room. A log was created for the nurse supervisor to record all temperatures. c. The administrator shall inservice the maintenance department on the correct temperature range for the medication rooms per policy and regulation. The nursing supervisor shall be responsible for documenting the ambient room temperature of the medication room.	9/15/13

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F 431	Continued From page 12 Findings: During a medication storage room inspection at Nursing station 1 on 8/12/13 at 11:56 a.m., it was noted there was no thermometer to monitor the room temperature. In a concurrent interview, when questioned, Licensed Nurse (LN1) wasn't able to locate the thermometer nor the temperature log for the drug room. In an interview on 8/12/13 at 1:20 p.m., LN1 explained there was a thermometer in the drug storage room and maintenance staff monitored the drug room temperature. In an interview on 8/12/13 at 1:30 p.m., the Maintenance Engineer 1 (ME1) stated, "No, we don't [monitor the drug room temperature]. Nurses do. We don't have keys." In an interview on 8/12/13 at 4:10 p.m., the Director of Nursing stated, "We [nurses] don't check the drug room temperature." The drug room temperature monitoring log was requested but not provided. A review of the facility policy and procedure titled, "Medication Storage," dated 09/10, under 4.1 Storage of Medication, Procedures, specified, "10. Medication requiring storage at 'room temperature' are kept at temperature ranging from 15°C (59°F) to 30°C (86°F). A daily recorded temperature should be documented and signed off."	F 431	d. The nursing department shall be responsible for monitoring temperatures. If the temperatures are out of range, a maintenance request will be completed. Compliance to this standard will be monitored by the quality assurance and assessment committee for review and action. e. This corrective action shall be done by September 15, 2013.	9/15/13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 13 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F441 a. The multiple residents receiving oxygen via nasal cannual, masks and tubing shall have these properly covered and dated. The personal urinary items were removed and new items provided and labeled with patient name. b. The certified nurses toured their assignments and ensured that all resident personal items were labeled.	9/6/13

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F 441	Continued From page 14 Based on observation, interview, review of clinical records and facility policies and procedures, the facility failed to establish and maintain an infection control program to provide a safe, sanitary environment and the help prevent development and transmission of disease for 1 out of 23 sampled Residents (19) and 1 Random Residents (K) when: 1. Multiple oxygen tubing, nasal cannulas and masks were undated and/or uncovered, and 2. Personal hygiene items were unlabeled in two different bathrooms used by a total of 11 residents. Findings: 1. During initial tour of the facility on 8/12/13 beginning at 8:10 a.m., multiple observations were made of undated and uncovered oxygen tubing's, nasal cannulas and masks. a. During an observation on 8/12/13 at 8:56 a.m., Resident 19's nasal cannula was found uncovered, connected to an oxygen cylinder, and on the floor. An oxygen mask was laying on the bedside table, uncovered, with tubing connected to an oxygen condenser. Neither the nasal cannula nor the oxygen mask were dated or covered. During a concurrent observation and interview with Licensed Nurse 6 (LN 6) on 8/12/13 at 9:05 a.m., she verified the above observations and said the nasal cannula tubing and the oxygen mask should be dated and covered with a bag. Review of the Nurses Admission Assessment, dated 8/6/13, documented Resident 19 came in	F 441	c. The director of staff development shall inservice the non licensed staff on the personal items being labeled for proper infection control. This shall be monitored by the medication nurses on each shift. The nurses shall check patient bedside areas and restrooms for proper identification of personal items daily.	9/15/13

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F 441	Continued From page 15 from the hospital with oxygen at 2 liters per minute by nasal cannula. Review of Resident 19's physician admitting orders, dated 8/7/13, indicated oxygen was to be administered at 2-5 liters per minute as needed for shortness of breath. b. During an observation on 8/12/13 at 9:22 a.m., oxygen tubing connected to nasal cannula was noted to be lying on the bed of Random Resident K undated and uncovered. Review of Random Resident K's undated admission "Physician Order Sheet", it indicated "Administer O2 [oxygen] via nasal cannula/face mask 2-5 liters per minute PRN [as needed] for SOB [shortness of breath]." 2. a. During the initial tour on 8/12/13 at 8:42 a.m., and an observation on 8/13/13 at 7:50 a.m., a pink bedpan was observed to be hung on the water pipe hook behind the toilet seat unlabeled in a bathroom shared by 6 residents. In an interview on 8/13/13 at 7:50 a.m., LN 5 verified the bedpan was unlabeled. b. During the initial tour on 8/12/13 at 9:15 a.m., and an observation on 8/13/13 at 7:55 a.m., the following personal urinary items were found in a pink bucket on the toilet tank in a bathroom shared by 5 residents: 1 urine measuring cup 2 urine hats (a urine measuring device that fits inside the toilet) 2 pink bedpans	F 441	d. The infection control nurse shall conduct weekly rounds for infection control and report findings to the quality assurance and assessment committee for review and comment. e. This shall be accomplished by September 15, 2013.	9/15/13

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F 441	Continued From page 16 In an interview on 8/13/13 at 7:50 a.m., LN 5 verified the above items were unlabeled and stated, "We put the names on and put them (personal urinary items) in their drawers." A review of the facility's policy and procedures titled, "Storage of Resident Personal Items," undated, under "Procedures," wrote, "1. Storage of Urinary article: ...All urinary items be labeled with residents name and room number."	F 441	F456 a. Resident 1 and 12 were provided replacement wheelchairs on August 17, 2013. b. The facility purchased 5 additional wheel chairs and will be given to residents that are in need of replacement chairs. c. The administrator shall inservice the maintenance staff on maintaining equipment in safe order. The facility will incorporate a system that provides a monthly check of all durable medical equipment that includes wheelchairs. Staff will log issues related to durable medical equipment in the maintenance log.	9/15/13
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the clinical record and facility policies and procedures, the facility failed to maintain patient care equipment in safe operating condition when wheelchairs were discovered without operating brakes for 2 of 23 sampled residents (1,12) and 1 of 21 random residents (J). This failure had the potential for a fall during transfer or accident should the wheelchair be unable to stop. Findings: 1. Resident 12 was admitted to the facility on 8/4/13 for physical therapy. Her diagnoses included a history of a mechanical fall and low back pain.	F 456		

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F 456	Continued From page 17 During a concurrent observation and interview with Resident 12 on 8/13/13 at 1:10 p.m., she said she had been given a wheelchair without brakes when she came into the facility. The resident also said she had told multiple staff and "They never sent anyone to fix it, either." Neither side of the wheelchair had a working brake. Resident 12 was unable to lock the wheelchair. During an interview with the Director of Rehabilitation (DR) on 8/14/13 at 8:25 a.m., he said Resident 12 "may have accidentally been given a wheel chair that needed repair." 2. Random Resident J was admitted 11/30/12 with diagnoses including weakness of one side of the body and a brain hemorrhage. He required a wheelchair for mobility. During a concurrent observation and interview with Random Resident J on 8/14/13 at 7:05 a.m., he pointed to the split rubber handle covering, with a metal lever underneath, on the right brake of the wheelchair. He said it had been like this for a couple weeks and he had "told the treatment nurse". It was not in the maintenance log. The Maintenance Log, dated June 1, 2013 through Aug. 14, 2013, was reviewed. There were no entries found requesting repair of resident wheelchairs. During an interview with Maintenance Engineer 2 (ME 2) on 8/14/13 at 7:58 a.m., he said that any of the facility staff could tell the maintenance department if wheel chairs needed repair between weekly cleaning on Wednesdays. He said "They don't tell us."	F 456	d. The administrator and the rehabilitation director shall make quarterly rounds to ensure that equipment is safe and adequately meets needs of residents. e. This corrective action will take place by September 15, 2013.	9/15/13

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F 456	Continued From page 18 During an interview on 8/15/13 at 7:32 a.m. with the Housekeeping Manager (HM), he said the facility had not kept up with wheel chair maintenance. The wheelchair repairs had been inconsistent. Review of the maintenance repair log at the front nurses station on 8/14/13 at 6:52 a.m. established no wheelchairs were documented as needing repair from 6/1/13 through 8/14/13. Review of the undated facility policy and procedure titled"Wheelchair-DME[durable medical equipment] Checklist" it established..."Monthly...Check that wheel locks/brakes are secured tightly to the frame and are easily activated." 3. Resident 1 was admitted to the facility on 10/20/12 for care of an abscess and ongoing care of cerebral palsy with mental retardation and other psychiatric diagnoses. During an observation on 8/13/13 at 11:45 a.m. Resident 1 was in the dining room awaiting lunch. Resident 1's wheelchair's armrest was cracked and peeled away in areas creating a rough area that would scratch and irritate skin. Resident 1 had behaviors that included picking at skin and the irritation from the rough armrest could increase this behavior. a staff member stated the Restorative Nurse Aide (RNA) reported this type of damage and she did not know if it had been reported. During an interview on 8/13/13 at 12:00 p.m. with the Restorative Nurse Aide (RNA), she stated that everyone, not just the RNA, is supposed to report needed wheelchair repairs and write the needs in	F 456		

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F 456	Continued From page 19 the log. She stated she did not recall the damage to the chair or whether or not she had reported the damage. Review of an additional undated policy and procedure provided by HM on 8/15/13, it established "...provide clean wheelchairs...that are in good repair for our residents."	F 456	F465 a. The vents in room 39 and 48 were cleaned. The vents between 39 and 43 were also cleaned. The vent in the bathroom in rooms 9 and 10 was replaced. The vents outside room 36 and 37 was covered. The missing grill was replaced. The ceiling tiles over the back nursing station were replaced. All ceiling tiles that had brown stains from ceiling leaks were replaced. The ceiling tile in room 34 were replaced. The light fixtures between room 38 and 47 was cleaned of debris. Much of the resident equipment was moved and covered. The mop buckets were moved from the outside patio to appropriate janitor closets.	9/15/13
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide a sanitary, well-maintained environment for a census of 114 residents when multiple areas in the facility were found to be dirty, or needing repair. This failure created the potential for infections or respiratory issues for residents, staff, and the public from ceiling tiles that were discolored from previously being wet and vents in rooms that were covered with dust and debris. Other maintenance issues created a potentially uncomfortable environment for residents. Findings: During the initial tour on 8/12/13 at 8:00 a.m. and general observations on 8/13/13 from 6:30 - 8:30 a.m. and throughout the survey, the following were observed:	F 465		

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F 465	Continued From page 20 > Dirty ceiling vents in the bathrooms of rooms 39 - 48. The ceiling vents were covered with fuzzy material to the point that the ducting and fan could not be observed beyond the vent (rooms 39 and 43). > The vent in the bathroom between rooms 9 and 10 had no cover. > Vents outside of the building and leading to resident bathroom ceiling vents were uncovered (outside room 36/37). One vent grill was on the ground below the vent and the other grill was missing. > Ceiling tiles over the back nursing station were sinking downward. > Multiple ceiling tiles in the bedrooms and hallway adjacent to the back nursing station had brown staining from ceiling leaks. > Ceiling tiles in room 34 had brown and pink staining. > The soap dispenser in the bathroom of room 43 was off of the wall and on top of the toilet. > Light fixture covers in the hallway outside of rooms 38 - 47 had debris visible and needed to be cleaned. > Resident equipment, (beds, commodes, etc.) was scattered outside the building under windows next to building and on concrete pads. Much of the equipment was uncovered. > Large rolling mop buckets were left in resident smoking patio area and garbage was thrown into the empty mop buckets. During an interview with the Maintenance Engineer 2 (ME 2) on 8/13/13 between 6:30 and 8:30 a.m., he made the following comments: > Regarding the stained ceiling tiles throughout the back part of the facility, ME 2 acknowledged the stained ceiling tiles. > Regarding the tiles falling in the back nursing	F 465	b. The maintenance department shall make rounds throughout the facility and put a system in place to address ceiling tiles, storage of equipment, vent cleaning amongst other issues. c. The facility has hired 4 full time FTE's to address maintenance issues inside the facility and on the exterior. A system will be put in place to address daily, weekly, monthly maintenance. Monthly rounds shall done and documented. d. This shall be monitored by the maintenance supervisor. The maintenance supervisor shall report to the quality assurance and assessment committee. e. This corrective action shall take place by September 15, 2013.	9/15/13

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F 465	Continued From page 21 station, ME 2 stated the ceiling could not be patched as the tiles were significantly different from the hallway tiles surrounding the nursing station. During an interview with the Housekeeping Manager on 8/13/13 at 10:30 a.m. he acknowledged the dirty vents in the bathrooms. He observed and acknowledged the mop buckets on the patio and the garbage in them. The Housekeeping Manager also noted the equipment outside the facility in multiple places. He stated some of the equipment had been cleaned and was stored outside as there was no longer a shed or covered space for the equipment. Some of the equipment was scheduled for disposal. Some equipment was covered and some not covered. Several items of resident equipment that the manager identified as being clean had not been covered after cleaning. During an interview on 8/15/13 at 11:00 a.m. with Licensed Nurse 5, the nurse stated there had been flooding in this room (34) and the ceiling brown and pink stains were from the water leaking.	F 465		9/15/13
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	1. ...ident #4 the MD was notified to come to the facility to sign the ICO for both the Haldol and the increase of the Seroquel. The License Nurse filled out the ICO and informed the MD to call the family to obtain consent for the two medications. 2. All residents needing usage of any psychotropic medication, the License Nurse will call the MD first, and have the MD call the family and obtain consent, then they will call the License Nurse back to verify with the nurse the approval from the family to give the medication. The License Nurse will have both the MD and family sign the ICO.	

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F 514	Continued From page 22 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documents were completed and signed by the physician, as required by facility forms and policy and by expectation of the Director of Nursing, in the clinical record for 1 of 23 sampled residents (4). Findings: Resident 4 was admitted to the facility on 5/12/13 following a hip fracture. Resident 4 had dementia with associated behavioral symptoms. The resident was on antipsychotic medications. Haldol, an antipsychotic medication, was ordered by the physician and the dosage for Seroquel, also an antipsychotic medication, was increased. During an interview on 8/12/13 at 3:10 p.m. with Licensed Nurse 7 (LN 7), LN 7 stated, "I can't find an ICO ["informed consent obtained" document] for the increased Seroquel. The original ICO was not signed by the MD either." The nurse checked the medication administration record. The increased dose had been given since 8/2/13. LN 7 checked the entire record looking for the missing document after the surveyor had not been able to find the document in the clinical record. During an interview on 8/14/13 at 3:25 p.m., the DON (Director of Nursing) was asked about her	F 514	3. The License Nurse will complete the ICO and notify the MD to call the family to obtain approval for the use of the psychotropic medication. The MD will return a call to the License Nurse to verify approval to give the medication. The License Nurse will have the MD and Family sign consent. If there are any changes or increase of the psychotropic medication a new consent form will be completed and the MD will contact the family again for the changes of the medication. 4. All Licensed Nurses were in-serviced on the proper steps and procedure to have the ICO completed. The Licensed Nurse will contact the MD, he will contact the family to get approval and then return a call to the nurse. The Licensed Nurse will have both the MD and family sign the consent form. The DON and medical record to audit all ICO to ensure that the MD and family have given approval for the psychotropic medications and have sign the consent. 5. Date completed 9-10-2013	9/5/13